Knowledge and Perceptions of Medical Abortion Among Potential Users

By S. Marie Harvey, Linda J. Beckman, Mary Ann Castle and Francine Coeytaux

Nearly two-thirds of 73 women aged 18–34 who participated in focus groups on medical abortion conducted in three cities had heard about this new abortion method, but only a few could describe it accurately. Once the method was described to them, they cited its potential advantages over vacuum aspiration as being fewer major complications, the absence of surgery, a greater "naturalness," and its use earlier in pregnancy. Women listed as disadvantages the multiple visits needed for medical abortion, the unknown aspects of the new technology, especially regarding the expulsion of the conceptus, and concern that mifepristone would make an abortion too easy and lead some women to take the decision lightly. More than one-third of discussants said they would choose mifepristone if the method were available.

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Currently, half of the pregnancies to American women are unintended, with about 28% of all pregnancies terminating in abortion.[1] For some women, particularly poor, young and rural women, obtaining a legal abortion has become more difficult over the past decade. A 1993 survey revealed that 84% of the counties in the United States had no abortion provider, and that between 1978 and 1992, the number of counties with an abortion provider declined by 31%. Moreover, the scarcity of abortion providers is greater in nonmetropolitan than in metropolitan counties.[2] Clinics that continue to provide abortions have been threatened, bombed and burned. The number of facilities willing to perform abortions has dwindled, and physicians who openly perform them have been physically attacked, shot and killed. Thus, even though the right to abortion has been upheld in the courts, access to abortion services is not guaranteed.[3]

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The introduction of medical abortifacients, and specifically mifepristone (RU 486), holds the promise of increasing access to abortion for women in the United States. The Population Council, after a very long and labored negotiation process, was granted the U.S. patent rights for mifepristone in May of 1994. In October 1994, clinical trials with 2,100 women commenced in over a dozen sites across the United States.[4] If approved for general distribution, the drug would not only widen the choice of abortion methods, but it could also expand women's access to much-needed services. The new medical technology, however, will increase access only if the numbers and geographic distribution of providers are expanded and if U.S. women find it acceptable.

The attitudes and beliefs of potential clients are known to play a critical role in the choice of contraceptive methods and the acceptance of new medical technologies in general. Although several studies have documented that pregnancy termination with mifepristone is well accepted by women in Europe,[5] very little is known about the attitudes of women in the United States toward mifepristone—whether or not they would choose it over surgical abortion or even how much they know about the new method. In this article, we report on findings from focus-group research that had the following objectives: to make preliminary inquiries regarding the depth of knowledge among U.S. women about mifepristone and the sources of that knowledge; to examine perceived advantages and disadvantages compared with surgical abortion; to investigate whether women would be likely to choose mifepristone if it were available; and to explore what types of additional information on the method women might want or need.

Methods

Focus-group discussions, a methodology that is predominantly concerned with observing, recording and assessing participants' perspectives, were used to address the research objectives. Such discussions offer concentrated insight into participants' thinking about and understanding of specific topics, and are particularly well suited to explore new research areas. However, by definition, since the number of focus-group participants is small and their selection is not random, findings should be interpreted with caution and should not be generalized to the broader population. Moreover, unlike the respondents to anonymous self-administered questionnaires, focus-group participants may feel a need to give socially desirable responses in the open group discussions.

In May 1994, eight focus groups were conducted with 73 sexually active women aged 18–34. To capture the diversity of women's experiences and perceptions about abortion methods, we separated the eight focus groups by race and ethnic background: three focus groups were held with 30 non-Hispanic whites, three with 27 blacks and two with 16 Hispanics. Similarly, to ensure that several geographic regions were represented, we conducted the sessions at three sites among those considered for the mifepristone clinical trials—New York City, Los Angeles and Portland, Oregon.

Women were recruited from family planning clinics in the three cities and were screened for eligibility using the following criteria: They were sexually active and not pregnant; they were between the ages of 18 and 34; they would consider having an abortion at some time in their life; and they had not had an abortion in the past two months.

Before the sessions began, all participants completed a brief questionnaire that assessed basic demographic information and reproductive history. Characteristics of the participants are shown in Table 1 (page 204). The mean age of the participants was 25.8 years, and their mean number of years

Table 1. Characteristics of women participating in focus-group discussions on medical abortion, by study site, May 1994

Characteristic	All	Los Angeles			New York			Portland	
		Black	Hispanic	White	Black	Hispanic	White	Black	White
Number	73	9	6	10	9	10	10	9	10
Mean age	25.8	24.2	26.0	25.1	25.6	27.0	21.7	29.8	27.0
Years of education	13.4	13.5	14.4	14.6	12.6	12.9	14.4	12.3	12.6
No. ever pregnant	46	7	5	4	8	6	0	7	9
No. ever used birth control	55	9	5	8	6	6	10	4	7
No. ever had miscarriage	9	0	1	1	2	2	0	2	1
No. ever had abortion	33	7	3	3	7	5	0	3	5
No. heard of RU 486	46	6	1	9	5	6	7	5	7

of education was 13.4 years. More than three-quarters of the women (78%) were single (not shown). Nearly two-thirds (63%) had ever been pregnant, and almost one-half (45%) had had an abortion.

Trained female moderators with the same racial and ethnic background as that of the participants conducted each of the focus groups. The moderators were members of a market research firm that specializes in qualitative data collection techniques, including focus-group discussions. The individual focus groups lasted for approximately two hours, and the moderator followed a semistructured topical guide to stimulate discussion on mifepristone.

Participants were first asked if they had ever heard of RU 486 and what they knew about the compound. (At the time of this study, both the media and the academic literature referred to the drug mifepristone as RU 486, and that term alone was used throughout the focus-group discussions.) After the ensuing discussion, members of each focus group reviewed an information sheet contrasting mifepristone with vacuum aspiration. The women were then asked to discuss the perceived advantages and disadvantages of each abortion method and to describe which specific characteristics would influence their choice. Finally, women were asked what factors might make RU 486 more acceptable to them. At the conclusion of the group discussion, participants completed a poststudy questionnaire asking which abortion technique they would choose and why.

The tapes of each session were transcribed by one research assistant and reviewed for accuracy by another. Then three members of the research team read the transcripts and each listed themes or elements from the discussions that addressed these three topics: knowledge and awareness of mifepristone; its perceived advantages and disadvantages; and gaps in knowledge about the drug. While we did not compute the frequency of mentions for each theme, team members discussed their individual findings and reached a consensus on which themes were most frequently mentioned and were most salient to the women. We calculated simple frequencies of responses to items in the prestudy and poststudy questionnaires.

Knowledge and Awareness

Before the sessions began, 63% of the participants indicated on their questionnaires that they had heard of mifepristone. In the ensuing group discussions, however, only a few women accurately described the drug and its purpose. Most participants expressed confusion, with some asserting that mifepristone is the morning-after pill. Others referred to it as the "abortion pill," and stated that they had heard that mifepristone was available in France and other foreign countries but not the United States. Several participants alluded to the story of a woman attempting to bring mifepristone into the United States illegally. The following quotations illustrate the participants' confusion:

"Aren't they the same thing—RU 486 and the morning-after pill?"

"They use it for women when they get raped. That is what I heard. I'm not sure, but they are trying to bring it over here."

"If you miss your period and you think that you're pregnant, you can take a pill in your medicine cabinet and your period will come."

Women cited newspapers, television programs and magazines as sources of information on mifepristone. They specifically mentioned the magazines *Cosmopolitan, Glamour* and *Newsweek,* and the television news programs, "20/20" and "60 Minutes."

Advantages and Disadvantages

After reviewing the written profile they were given describing the characteristics of the two abortion methods (see Table 2), the participants in each focus-group session cited a number of characteristics that they perceived as advantages of mifepristone over vacuum aspiration, with the following four being mentioned most often—the method has fewer major complications and no risk of perforation of the uterine wall; it is a nonsurgical procedure not requiring anesthesia; the method is natural and noninvasive; and it can be used relatively early in pregnancy.

Many women responded favorably to the method's nonsurgical nature and the lack of need for anesthesia:

"Because I wouldn't want to be vacuumed out. It really does not sound pleasing to me at all. I would rather have my clothes on and one pill, the first pill is nothing. You just take it. The second is the one that really matters…You're just taking a pill."

"The disadvantage [of vacuum aspiration] is the general anesthesia. Any time you use general anesthesia, you run the risk of death."

Participants also commented that mifepristone seemed more natural because it is less invasive and feels more like a natural miscarriage. They associated vacuum aspiration with the forcible insertion of medical instruments into the body that would, literally, "take" the fetus from them. Mifepristone, on the other hand, was perceived as a more natural process in which the body "expels" the fetus:

"I like the fact that you pass it yourself, which is good. It is basically a miscarriage. Instead of having it sucked out of you, you pass it out yourself, which is, I'm sure, a little bit easier on your uterus. And it is probably quite a shock when something is sucked out of you and then you've got to adjust,…with natural cramping everything gets back to normal size."

"It seems it would be more holistic, more natural. Like it's all taking place from within your body and there's no instruments or human error involved."

Many women reacted more favorably to mifepristone than vacuum aspiration because they perceived there would be fewer major complications, especially no risk of perforation of the uterine wall:

"...the instrument used for the vacuum aspiration can perforate your uterus and that can cause severe, I mean real extreme, problems. [RU 486] sounds so much easier and safer."

"It's a nonsurgical procedure. Less chance of bacteria, infections, puncturing, and it is just better."

Finally, the overwhelming majority of women considered mifepristone's use earlier in pregnancy to be an important advantage. Many affirmed that they would prefer to have an abortion as soon as pos-

sible after deciding to have one, and that they would rather not wait until the seventh week of pregnancy. They remarked that having an early abortion would probably be both physically and psychologically easier than having a later one:

"The earlier the better because maybe that won't cause a lot of problems to you as well as the fetus."

"When I was six weeks, the doctor said 'you have to wait a couple more weeks for the vacuum aspiration.' And I'm like, now, I want to do this now, now, now! I didn't want to wait."

"You won't be as pregnant...terminate it before it's even . . . the fetus."

Participants perceived four primary disadvantages of mifepristone compared to vacuum aspiration—the multiple visits needed for the method and the two-day wait required between taking mifepristone and the prostaglandin; the fact that mifepristone is an unknown and unfamiliar new technology; that the expulsion of the conceptus might be visible or painful; and that mifepristone might make having an abortion too "easy," which could lead women to neglect using contraceptives.

Women mentioned that having to make more than one visit was a hassle (requiring extra arrangements for transportation, child care, time off from work or school, etc.), and that they were afraid that each visit would take a long time. Similarly, most women perceived the two-day wait between pills as a disadvantage and suggested that the prolonged wait could heighten the psychological trauma of having an abortion for some women. The participants also wanted to know if a woman could change her mind after taking the first pill, and what effect, if any, that would have on the fetus if the pregnancy were carried to term. The following comments convey some of the reservations women had regarding the method:

"It's time-consuming. If they could cut down the time, then it would probably be a lot more effective. It's time-consuming if you're working or something like that. With vacuum aspiration, you're in, you're out, and that's it."

"I think that the RU 486 is a more traumatic process. The fact that you have to go through visiting the doctor twice and then you have a follow-up visit two weeks later and you sit in a room, maybe with other people who are also having the same process done, I think it's very traumatic."

"That will be a long two days. You get a lot of questions in your head—oh my God, maybe I shouldn't be doing this."

"What happens if somebody takes the pill the first day and they chicken out and don't go through with it? What would happen to your body then?"

"I live two hours away…. Would I have to drive up here to get one pill, go home or stay in a motel and get the other pill?"

Many women were uncomfortable with mifepristone and did not fully trust the method because it is a new and unfamiliar technology that is still not approved for use in the United States. Did this mean it was dangerous? Many wanted to hear others' stories about using mifepristone before they would choose it, as the following comments attest:

"I think I'd stick with the old, tried and tested method...because so many things go wrong. So many newer products, oh they're great and all the rest, and a couple years down the road, all these side effects start popping up."

"Regarding the old and the new, it would be good to read what has happened in Europe, where they have used it. And to know what has happened to those women there. I would like to know the experience of other persons."

"...the fact that it is not presently available for use in the United States is a turnoff, 'cause it is like, why isn't it available for use here?... I mean, what is the problem, why can't it be over here?"

In addition, women were concerned about issues surrounding the expulsion of the conceptus. Some participants were concerned that many women might complete their abortion after leaving the clinic; this was perceived as a distinct disadvantage. For example, women expressed fear that they would expel the tissue while on a bus, a train or the street. They were also afraid they would not be able to tell the difference between a regular blood clot and the expulsion of the conceptus, and they were fearful of what they would "see." For some women, this aspect of a medical abortion procedure was particularly disturbing, since they feared that it would increase the trauma of what was already a psychologically difficult experience:

"That means that it could come out on your way home, at home, watching TV, on the bus, the train or while you're stuck in traffic."

"Now to see big blood clots, that's a scary thing. I don't want to see someone else's blood clot, but I want to know, are they going to be extreme? I want them to tell me. Are you going to see something in the shape of a baby? Something solid? Something formed? I just want to know what I'm going to see."

A final concern stated by many participants was that mifepristone's comparative ease would lead women to use it in place of birth control, to take the decision to have an abortion too lightly:

"People are already irresponsible. With that [RU 486] available they would be less responsible than they are now."

"I feel that this [RU 486] would be abused very much."

"I feel that it [RU 486] will be an easy street for a lot of people."

Table 2. Information sheet listing characteristics of vacuum aspiration and medical abortion

Vacuum aspiration	RU 486 medical abortion
Available from about the 6th week from the last menstrual period through the 13th week.	Available from when you find out you are pregnant up to 8 weeks from the last menstrual period.
Removal of the contents of the uterus through a tube that is inserted through the cervix.	A pill that, when used in combination with another pill, causes the contents of the uterus to be expelled.
Requires one visit to doctor for actual procedure and then doctor recommends a follow-up visit two weeks later.	Requires one visit for the first pill, another visit for the second pill two days later and doctor recommends a follow-up visit two weeks later.
Takes 10–15 minutes for the abortion procedure, but requires an hour or two in the clinic.	Second visit may take several hours. Women wear sanitary napkins and sit together in a waiting room fully clothed, waiting for the abortion to occur.
Women complete their abortion during the procedure.	Most women complete their abortion while at the clinic, expelling a small mass of tissue similar to a blood clot. Others will complete the abortion after leaving.
A local anesthetic (painkiller) may be injected into the cervix or a general anesthesia (put to sleep) may be used, but some women still feel pain and nausea during and after the procedure. Bleeding occurs on the average for 7 days following the abortion.	Most women experience cramping and some have nausea. Bleeding occurs on the average for 10 to 12 days and is similar to a heavy, somewhat prolonged menstrual period.
Almost 100% effective.	About 96% effective.
Extremely safe. Over 95% of all abortions in the U.S. are performed using this procedure.	Extremely safe. Although not presently available for use in the U.S., nearly 150,000 women in 20 different countries have used RU 486 to terminate early pregnancy.
Possible complications include infection, perforation (one of the instruments goes through the wall of the uterus) and incomplete abortion.	Possible complications include heavy bleeding and incomplete abortion.

In response to the following item in the poststudy questionnaire, "if you were pregnant and had decided to have an abortion, which method would you choose and why would you make this choice?" 27 of the 72 women responding said they would choose mifepristone, 25 would elect vacuum aspiration and 20 were undecided (see Table 3).

More than three-fourths of the 27 women who selected mifepristone said they would favor medical abortion because it avoids surgery and anesthesia. One-third of these women cited the absence of the risk of uterine perforation or infection as one of the reasons for their choice. Among the 25 women who chose vacuum aspiration, the majority listed familiarity and proven effectiveness as the main reasons for their choice, and about half, the method's relative ease and quickness compared with mifepristone. Among the 20 women who were undecided, half said they had difficulties weighing the pros and cons of each method, and almost as many said they did not yet have enough information to make a decision.

Gap in Information

Discussants in general felt they needed more information to make an informed decision about whether to use the new method. Several wanted to know more about the drug's legal status and cost:

"Is RU 486 still under testing?"

"How much will the RU 486 procedure cost?"

"Will the state or federal government cover women who want to use RU 486?"

"Will the government allow me to choose which type of abortion I will have?"

Other questions highlighted the need for more information about the chemical composition and dosage of the two pills, and the procedures for taking them:

"What chemicals are in RU 486? How do they work?"

"What specifically does each pill do? Why are there two pills and is it necessary that there are two pills? Why not combine them into one pill?"

"Is there just one dose of RU 486 or is the dose calculated for each woman?"

"Why can't I take the second pill at home?"

Still other women wanted a fuller description of the medical abortion process and procedure:

"What kind and how much doctor supervision will I receive?"

"How many hours will the second visit entail?"

"Can I change my mind between the first and second pill as to whether to have an abortion?"

"How will I know if the RU 486-induced abortion is complete?"

"What will the expelled material look like?"

"How is the expelled material handled after the abortion is complete?"

"Does the placenta come out with the fetus?"

Finally, the majority of participants asked for an in-depth explanation of mifepristone's potential side effects and complications:

"Really, how much pain is there? Will I be given anything for the pain?"

"What are the statistics on incomplete abortion and other side effects?"

"What are the consequences to me and the fetus if I do not take the second pill?"

"Are incomplete abortions more frequent late in the pregnancy?"

"What are my options if the RU 486-induced abortion is incomplete? Do I start all over again with RU 486, or have a vacuum aspiration?"

"When will my body return to normal reproduction after RU 486 is used? How will RU 486 affect fertility?"

"How long must I wait between RU 486 medical abortions?"

"What are the side effects of repeated use of RU 486?"

Table 3. Number of focus-group participants, by abortion method they would choose and reasons for preference

Method and reason	No.
Vacuum aspiration	**25**
Familiar, proven effective	15
Quick, easy	12
Safe	3
RU 486 too unknown	2
Less psychological trauma	2
Anesthesia use	2
Medical abortion	**27**
Avoids invasive procedure and anesthesia	21
No risk of perforation or infection	9
Easy, convenient	6
Natural	6
Puts woman in control	3
Less pain and discomfort	3
Can be done earlier	2
Other	4
Undecided	**20**
Difficulty weighing pros and cons	10
Not enough information	9
Situation-dependent	6

Note: Data collected in poststudy questionnaire.

Discussion

Focus groups of young women were used to elicit their perceptions, knowledge and understandings of medical abortion techniques. The reasoned responsibility displayed by participants as they considered the choice of a particular medical treatment was noteworthy. The responses and questions of the women, which were intelligent and thoughtful, are invaluable to the development of counseling materials for patients and providers, as well as for appropriate educational messages to inform women about new abortion methods. We are also using the findings for data collection in a study comparing the acceptability among U.S. women of medical abortion (mifepristone and misoprostol) and of surgical first-trimester abortion.

Several of the perceived advantages and disadvantages of mifepristone mentioned by women in our focus groups parallel the reasons women in international studies gave for choosing medical abortion. Despite the variability in the research designs of the 12 published studies that have examined the acceptability of medical abortion,[6] the findings are remarkably uniform. Fear of surgery and general anesthesia is consistently documented as a reason for choosing medical abortion in both the previously published studies and among the women in our focus groups. The women in the international studies said they would prefer medical abortion because it causes "less injury to the body" and seems more "natural" and like a "premeditated miscarriage,"[7] and our focus-group participants also attributed fewer major complications to medical abortion. However, both the U.S. discussants and those who participated in the international studies cited the multiple visits associated with medical abortion and the length of the procedure as negative characteristics of the new method.[8]

While the possibility of verifying the expulsion was significantly associated with choosing medical abortion in a study of French women,[9] the women in our focus groups perceived seeing the products of conception as a disadvantage. In addition, unlike the women in France, where medical abortion has been available for nearly 10 years, U.S. women were uncomfortable with mifepristone because it is a new and unfamiliar technology. These data suggest that if mifepristone becomes available for general use in the United States, the numbers of women who would find it acceptable will likely increase.

Several focus-group participants mentioned how difficult the decision to terminate a pregnancy was and how ambivalent they felt about their decision. These comments suggest that women do not make the decision to have an abortion lightly, and they highlight the importance of preventing unintended pregnancies.

On the other hand, many women in our study were concerned that mifepristone would make the abortion procedure too "easy" and would allow "other" women to take too lightly the decision to have an abortion. This finding is unique to our study, and may be partly due to the political nature of abortion in the United States, where the morality of abortion remains a highly volatile and contentious issue. Women often have to seek abortions in an unsupportive and hostile political climate characterized by antiabortion harassment and violence. The focus-group participants may have thus felt the need to acknowledge and discuss the moral issues surrounding abortion.

More than one-third of the discussants had never heard of mifepristone, and the majority expressed confusion and inaccurate information about the method. This was a surprising finding, because there was widespread and accurate reporting in the media about mifepristone during the period when the focus groups were held. The timing of the data collection coincided with a press release from The Population Council announcing that the French manufacturer of mifepristone, Roussel UCLAF, had transferred the U.S. patent rights to The Population Council, which was proceeding with clinical testing.

Our findings indicate that women want to make educated medical decisions, and to do so they need and want detailed information. A need exists for comprehensive educational materials to assist women in making reasoned decisions about the use of mifepristone. The current communication gap, if unaddressed, may prove to be more of an obstacle to acceptance than any inherent attributes of the abortion procedure.

A major disadvantage of mifepristone as identified by the study group, for example, was the expulsion of the conceptus, which provoked anxiety about what women would see. A simple and reassuring way to alleviate this anxiety could be to offer women the option of seeing a picture of the products of conception at the sixth week of pregnancy. Alternatively, as is done in France, women could view a bottle containing the blood clots and tissue of a six-week pregnancy. These proposed procedures could alleviate anxiety by reducing the unknown aspects of this new technique.

The findings from this focus-group study highlight the diverse needs, perceptions and lifestyles of women in the United States. Mifepristone was not perceived as a "magic bullet" by the participants, nor was it accepted as a method of choice by all women. However, more than one-third of the women said they would choose mifepristone over surgical abortion if it were available. The focus-group data support the development and distribution of new abortion technologies that provide women with a choice of methods, and they highlight the need for educational materials to assist women in choosing between available methods.

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